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VIA ELECTRONIC FILING

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re*: Ex Parte Communication regarding Rural Health Care Universal Service Support, WC Docket No. 02-60*

Dear Ms. Dortch:

On September 30th, 2013 I talked with Linda Oliver (Deputy Chief, Telecommunications Access Policy Division) and Christianna Barnhart (Attorney Telecommunications Access Policy Division) of the Wireline Competition Bureau about the Healthcare Connect Fund Order and specifically about the limits to upfront payments for consortia applicants of the Fund. I conveyed that I believe there are several important issues to consider when interpreting the up-front payment limit language, including the following:

Intent of the HCF Order Limitation on Upfront Payment Language

The focus of our communication related to HCF Order paragraph 190, which I am inserting directly below.

"190. Third, we impose a $150 million annual limitation on total commitments for upfront payments and multi-year commitments.[512] We do so in order to limit major fluctuations in Fund demand, although we anticipate that the $150 million should be sufficient to meet demand for upfront payments given the other limitations we impose in this section. Fourth, we will require that consortia prorate support requested for upfront payments over at least three years if, on average, more than $50,000 in upfront payments is requested per HCP site in the consortium.[513]

513 For example, if an eligible hospital owns an eligible rural health clinic which is located in a different town, the $50,000 limit would apply separately to the hospital and to the rural health clinic The $50,000 limit only applies to upfront payments, not recurring charges. Furthermore, $50,000 is an average per site limit; it is not a limit on the upfront payments that can be requested for any individual HCP. We apply this methodology in order to ensure that HCPs

located in areas where access to broadband facilities is particularly expensive to obtain can participate in consortia. For example, if a consortium has four sites, upfront payments for the consortium must be prorated over at least three years if the amount of upfront support requested is more than $200,000 ($50,000 x 4). Within the consortium, one site may need $100,000 in build-out costs, and another may only require $25,000."

My comments relating to this language included the following

- The sentence "…*if, on average, more than $50,000 in upfront payments is requested per HCP site in the consortium*" in my opinion means that the average is determined by the number of HCP sites in the consortium. This seems straightforward, but it is possible to interpret this language to mean that the average is determined by the number of HCP sites in a given funding request (i.e. the number of sites that appear on an individual 462 form). The problem with the latter interpretation is that many consortia (including the one I represent) will have multiple 462 forms (since a different 462 needs to be used for each vendor contract), and tying the average to the number of HCP sites in a given 462 form will significantly reduce the average amount compared to what it would be if all consortia members—irrespective of whether they appear on the same 462 form—were counted. Consortia such as ours utilize a multi-vendor strategy in order to get the best prices in a given location, and disadvantaging such a strategy is likely to lead to higher total costs incurred by the Fund and by individual HCPs. I therefore encourage the commission to explore alternative ways of determining how many HCP sites are in a consortium any given year in order to calculate the average.

- A related issue is whether all of the sites in a consortium should be included in the average calculation, or whether it should only be the subset of sites with an upfront funding request. From my perspective, the Order does not specify that the average should be calculated using only the number of HCP sites in a consortium with upfront payment requests but states that it should be "per HCP site in the consortium." It is in my opinion unreasonable to interpret the footnote language ("*The $50,000 limit only applies to upfront payments, not recurring charges."*) to imply that only HCP sites with upfront payment requests should be used to establish the average. The footnote language is simply establishing that recurring charges can be higher than $50,000 and does not appear to be addressing the issue of how the average is established. I therefore encourage the commission to allow all consortia HCP sites to be included in the average, rather than just those with upfront requests.

Determining How Many HCP Sites are in a Consortium

If the Commission agrees that it's reasonable to include all the HCP sites in the consortium to establish the average, the question of what constitutes consortium participation remains. Below are some options for establishing the number.

- One option is to include every eligible HCP site in the 460/461 application. This number would include the sites of all of the HCPs that have signed LOAs to participate in the consortium. However, it is important to note that only a subset of these HCP sites will go

on to contract for services that will be included in a 462. For example, the consortium I represent has 70 sites in our 460 form, and it is likely that only about 40 of those will go on to select bids they received pursuant to our RFP. The remaining 30 may select bids at a later time pursuant to other RFPs or be contracted through site substitutions using Master Agreements that contemplated such substitutions, but they may not. The 70 sites are covered by letters of agency, so it is only to the extent that LOA signature is sufficient to consider an HCP site as part of the consortium that all of the sites listed in the 460/461 would be counted toward the average. The benefit of this approach is that a fixed number of HCP sites can be established early in the funding year.

If this number were used as the average, then a consortia such as ours that had 70 sites with LOAs would have a limit of $3,500,000 in upfront cost funding commitments before the need to prorate the upfront payment over at least 3 years.

- Another option is to add up the HCP sites in multiple 462s. For example, the consortium I represent currently has five 462s submitted with 15 HCP sites included. And we expect to have another five to ten 462s submitted with 20-30 sites before the end of December. Would it be possible to establish the average by counting every site that has received a funding commitment pursuant to a 462 request? The problem with this approach is that the requests will be processed at different times during the funding year and the average will change with every new funding commitment. But there may be a way to establish a rolling average with a maximum average amount that grows over the funding year as additional HCP sites receive funding commitments. I recognize the administrative complexity in using this option, but consider the following process:

  Early in the funding year, the consortium submits funding requests and receives FCLs for 15 HCP sites and thereby establishes an initial pool of $750,000 for upfront funding commitments. The $750,000 pool continues to grow by $50,000 with each new HCP site that receives a funding commitment. Non-prorated upfront funding commitments for that year are limited to the amount that is available in the pool at the time the funding commitment request is made.

- Another option is to perform a look back to the previous year to establish at least a minimum number of HCP site participants based on the HCP locations with funding commitments in place for that year. The problem with this approach is that it doesn't work for Year 1 and it can significantly undercount consortia sites for consortia that grow in any given year. However, starting in Year 2 this mechanism could be used to establish the initial pool for the upfront cost funding commitment limit, which then could be increased with a separate mechanism designed to account for growth.

Recommendation

- My recommendation is to allow any consortium in Year 1 of participation to count every HCP site included in consortium LOAs toward the average in order to establish a pool of available funds that can be used for upfront payments (upfront payment pool equals number of HCP sites with HCF consortium LOAs multiplied by $50,000) before the

consortium would need to prorate any additional upfront costs over at least 3 years. For Year 2 of participation and after, I recommend that at a minimum all HCP sites with funding committed for that year be included in establishing the available amount for upfront payments (upfront payment pool equals the number of HCP sites with HCF funding committed for that year multiplied by $50,000) before needing to prorate any additional upfront costs over at least 3 years. Additionally, for Year 2 of participation and after, I recommend the Commission consider administratively feasible ways to add new sites to this proposed upfront payment pool calculation, to account for the likelihood that many consortia will experience significant growth over time.

I will continue to consider this issue and will submit additional comments as necessary based on my consortium's experience with the HCF program.

Please contact me if you have any questions.

Sincerely,

Louis Wenzlow
Executive Director
Rural Wisconsin Health Cooperative Information Technology Network